CORRESPONDENCE

Is It Right ASA Scoring to be Used in Identification of Nonoperated Patients?

Although with limited number of patients, we appreciate the authors for their study investigating the rates of rupture and mortality that was developed in inoperable abdominal aortic aneurysm.[1] First we wanted to state a technical mistake in the paper that drew our attention. Despite the total number of patients included in the study is 72, there are 71 patients in Figure 1. Since the number of patients is small, we believe that this missing patient should be included in the relevant group. However, our actual review about the article is that the authors grouped the patients according to the ASA and gave the number of deaths and ruptures of these groups. Several studies reported ASA scoring to be effective both on anesthesic and surgical outcome.[2,3] However, we believe that this parameter which is used in preoperative risk scoring should not be used to identify nonoperated patients. Already looking to Figure 1, survival rate in the ASA 4 group (48%) is seen to be unexpectedly higher than ASA 2 group (38%). This shows us that evaluation of the risk for rupture and mortality between ASA groups is meaningless. We would want to say that we wonder about the views of the authors on our this critics.

REFERENCES

1 Western CE, Carlisle J, McCarthy RJ, Currie IC. Palliation of abdominal aortic aneurysms in the endovascular era. Eur J Vasc Endovasc Surg 2012 Nov 14.

2 Wisniowski B, Barnes M, Jenkins J, Boyne N, Kruger A, Walker PJ. Predictors of outcome after elective endovascular abdominal aortic aneurysm repair and external validation of a risk prediction model. J Vasc Surg 2011 Sep;54(3):644—53.

3 Barnes M, Boult M, Maddern G, Fitridge R. A model to predict outcomes for endovascular aneurysm repair using preoperative variables. Eur J Vasc Endovasc Surg 2008 May;(5):571—9.

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Re. 'Is It Right ASA Scoring to be Used in Identification of Nonoperated Patients?'

Sir,

We thank Dr Gokalp and colleagues for their interest in our paper on palliation of aortic aneurysms. Our study contained 72 patients however, we were unable to determine cause of death in one individual as they died abroad and therefore we were unable to include them in the analysis of cause of death.

ASA grade has been used in many studies to stratify surgical risk.[1,2] ASA grade is only one factor considered in our unit when deciding suitability for aneurysm repair and, unsurprisingly, the majority of patients included in this study were ASA-3 (41) or ASA-4 (22). Of the small number of ASA-2 patients (8), five declined operative intervention, some of whom would have been suitable candidates for aneurysm repair, so possibly changing subsequent outcome (25% of this cohort died of rupture). We therefore feel that as the majority of this group in our study self-selected themselves out of surgery, they cannot be seen as representative in terms of outcome.

Following assessment by a Consultant Vascular Surgeon, patients in our unit are subjected to CPEX testing and Consultant Anaesthetist review. This was not consistent in the early days of our CPEX programme but is standard practice now. All these factors are combined to give a definitive judgement on suitability for intervention at this point in time. This can be revisited in the future if aneurysm expansion shifts risk-benefit ratio in favour of surgery.

REFERENCES

1 Lomazzi C, Mariscalco G, Piffaretti G, Bacuzzi A, Tozzi M, Carrafiello G, et al. Endovascular treatment of elective abdominal aortic aneurysms: independent predictors of early and late mortality. Ann Vasc Surg 2011;25(3):299—305.

2 Zannetti S, DeRango P, Parlani G, Verzini F, Maselli A, Cao P. Endovascular abdominal aortic aneurysm repair in high-risk patients: a single centre experience. Eur J Vasc Endovasc Surg 2001;21(4):334—8.

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